EXHIBIT 13

Reilly, Cecilia F

om: Ostlund, Steven <Steven.Ostlund@insurance.alabama.gov>
Sent: Friday, March 04, 2016 12:09 PM
To: Healey, Kathleen
Subject: RE: Rate Review survey
Attachments: Sample rate review workplan.docx

Maybe not yet final? Top of page 3 we still have "CCIIO" rather than CMS. Also, new item from me, on question 12 bottom of page 10, instead of:

HMOs have 30 days per Ala. Code§27-21A-7(c)
Health care service plans have 30 days or it is deemed approved under Ala. Code 10A-20A-6.10
Can we eliminate reference to "deemed", parallel HMO language, and say:
HMOs have 30 days per Ala. Code§27-21A-7(c)
Health care service plans have 30 days per Ala. Code 10A-20A-6.10

It just removes a potential "yellow" flag.

The revised work plan is attached. It looks good to me.

Is there anything we wanted to communicate in the e-mail transmission, like "please respond by Tuesday March 8!"? Or maybe something to let them know about the pressure if we need legislation?

ven Ostlund
L and H Actuary
Alabama Department of Insurance
Rates and Forms Division
Email steven.ostlund@insurance.alabama.gov
Ph 334-240-4424

From: Healey, Kathleen
Sent: Friday, March 4, 2016 10:43 AM
To: Ostlund, Steven
Subject: RE: Rate Review survey

Here is the final.

From: Ostlund, Steven
Sent: Friday, March 04, 2016 8:33 AM
To: Healey, Kathleen <Kathleen.Healey@insurance.alabama.gov>
Subject: FW: Rate Review survey

I need to look at this. I answered you before I saw this.

Steven Ostlund
d H Actuary
bama Department of Insurance
Rates and Forms Division
Email steven.ostlund@insurance.alabama.gov
Ph 334-240-4424

From: Matson, Tricia [mailto:Tricia.Matson@riskreg.com]
Sent: Friday, March 4, 2016 6:03 AM
To: Ostlund, Steven <Steven.Ostlund@insurance.alabama.gov>
Subject: FW: Rate Review survey

Steve –

Craig Moore has been working very closely with CCIIO, in particular related to MLR requirements. He had some good comments that came to me late last night, and I wanted to share for your information.

Thanks.

Tricia

From: Moore, Craig
Sent: Thursday, March 03, 2016 10:17 PM
To: Matson, Tricia <Tricia.Matson@riskreg.com>; Spencer, Margaret <Margaret.Spencer@riskreg.com>; Reimer, Dave <Dave.Reimer@riskreg.com>
Subject: RE: Rate Review survey

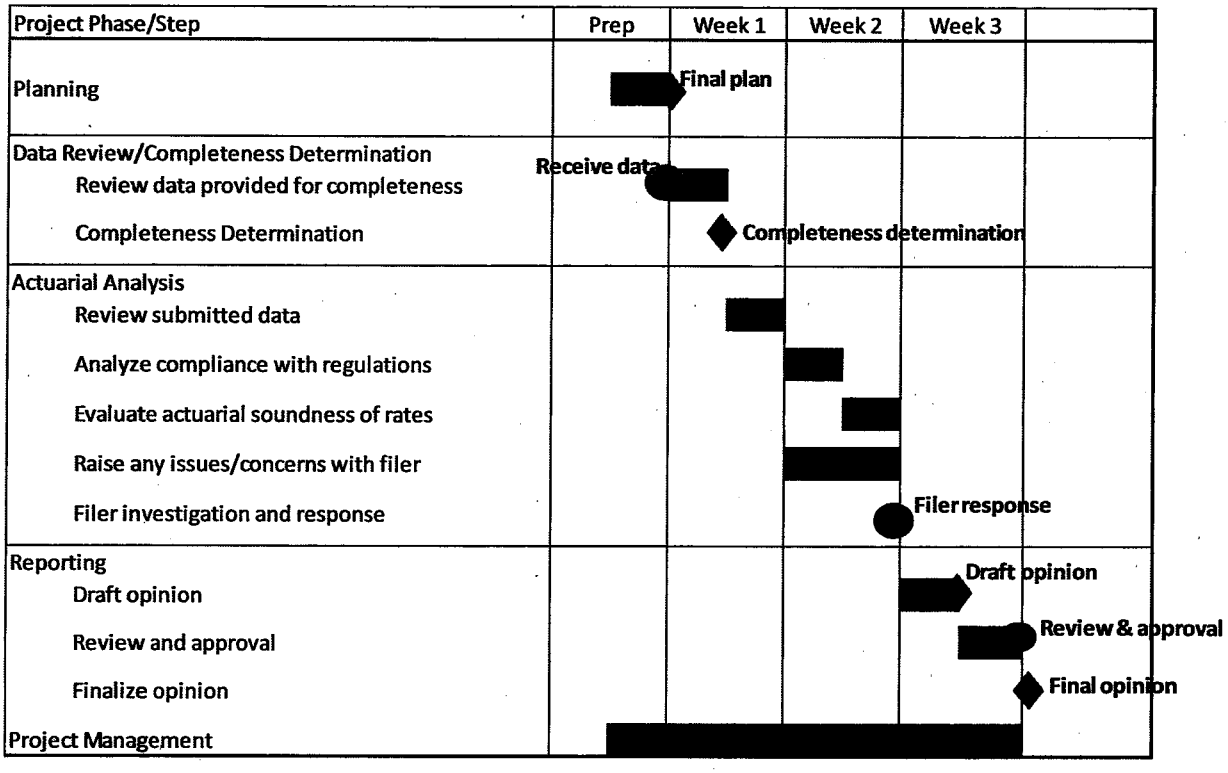
Tricia, sorry I didn't get this back earlier. Please see attached for some comments in the margin on questions 2, 3, 5, 7c, 8, 10a, 11, 13b.

Please let me know if you have any questions.

Craig

DISCLAIMER:

Below is a high level summary of the steps performed for each rate review, as well as approximate timing. Reviews can typically be completed in three weeks or less, assuming information is provided in good order and responses to questions are provided in a timely manner. Additional details regarding each step is below. Red diamonds in the flowchart represent key output from the reviewing actuary during the process while green circles represent key points of interaction with the filing insurer and reviewers of the work product.



Step I – Planning

We recognize that planning, especially related to complex and time-sensitive health rate reviews, is critical and we are sensitive to the need to effectively manage the planning process to ensure the work is conducted in a timely and cost efficient manner. During the planning step the Lead Reviewer collaborates with other key stakeholders to discuss and confirm the planned approach, and discuss any special considerations for the specific filing.

Step II – Data Review/Completeness Determination

In this step, we review the data uploaded by the insurer to SERFF for completeness. To evaluate completeness, we compare the uploaded information to the filing requirements per the rating checklist, also considering state rating laws as well as the requirements of the federal regulations under the Affordable Care Act (CFR 154), as applicable. This review is performed at a high level, however it involves review of the documentation provided relative to the requirements and a cursory review of the documents themselves, to identify any potential issues with the completeness of their contents. For example, we review the actuarial memorandum provided in support of the Unified Rate Review Template (URRT) to evaluate whether all assumptions used are justified with supporting data or other

relevant support, considering the federal requirements as well as applicable actuarial standards of practice.

Upon completion of this review, we develop a written assessment of completeness, either confirming that the data is complete or identifying any gaps or issues that must be remedied by the insurer. This review and written assessment is typically completed within one week of receipt of the data.

Step III – Actuarial Analysis

We review in detail the information submitted, including items such as the following:

- Rating checklist
- Unified Rate Review Template (URRT)
- Actuarial certification and memorandum
- Manual rate pages
- Rate filing justification
- Network information

We consider whether the ultimate rates to be charged are consistent with actuarial experience data as applicable, appropriately consider the changes occurring in the marketplace, and are actuarially sound. Considerations in this evaluation include, depending on the type of filing, the following:

- Overall consistency with the requirements of the ACA, including minimum loss ratio requirements, application of the "metal" tiers using the actuarial value calculator (AV calculator) or alternative methods, development of the index rate, market adjustments, issuer adjustments, and calibration factors
- Assessment of whether premiums and claims resemble the Supplemental Health Care Exhibit for the selected market
- Justification of rate increases, including specifics regarding the drivers of the increase and evidence of the appropriateness of the increase in light of the drivers
- Appropriateness of experience data used, including any adjustments needed and/or made related to differences in the experience data and the expected future claims due to enrollment changes and transitional provisions of the ACA
- Appropriateness of any other adjustments to the experience data
- Accuracy and completeness of historical data used

- Evaluation of methodology for developing ultimate incurred claims, including any special considerations regarding changes to claim payment and premium patterns introduced by the ACA and associated transitional period
- Methodology used to assign claims to the applicable URRT benefit categories
- Use of trend to project experience benefits to the rating period, including demographic adjustments, morbidity adjustments, medical cost trend adjustments, and benefit changes
- Assessment of the credibility of the data and credibility methods used
- Effect of the reinsurance and risk adjustment mechanisms on claims costs, including consideration of statewide experience for risk adjustment and nationwide experience for reinsurance, which impact the overall level of payment/reimbursement expected
- Expenses and profit charges, including documentation of the expense allocation methodology as applicable
- Details of the development of the index rate and market-adjusted index rate
- Details of the development of the plan adjusted index rate, including actuarial and cost sharing adjustments, network, delivery system, and utilization management adjustments, adjustments for benefits other than essential health benefits, adjustments for distribution and administrative costs and adjustments for catastrophic plan eligibility categories
- Consideration of state regulatory requirements, including age, tobacco, family tier, per member, and geographic rating requirements as well as composite rate requirements
- Appropriateness of consumer level adjustments
- Lifetime loss ratio, and approach to incorporating reserves in the analysis
- Consideration of moderately adverse experience in the analysis
- Compliance with applicable Actuarial Standards of Practice

Ongoing communication is an important part of the process. We conduct regular discussions among key stakeholders and to the extent clarification is needed with the company, make requests for additional information as needed. The timing of this work is dependent on the responsiveness of the filer.

Step 4 - Reporting

Our work product is summarized in a formal opinion, which includes a record of work performed, the conclusion statement of the reviewing actuary, as well as any findings.

The draft opinion is issued upon completion of the review, typically within 2 weeks after the completeness determination.

The work carried out is under the active direction and supervision of a Fellow of the Society of Actuaries and the report is signed by the lead reviewing actuary.